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Law Department - Litigation

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IN THE CIRCUIT COURT OF THE STATE OF OREGON  
FOR THE COUNTY OF UMATILLA

BRADLEY D. ZIMMER,	)	Case No. 18CV19798
	)	
Plaintiff,	)	SUMMONS
	)	
and	)	
	)	
METROPOLITAN LIFE INSURANCE	)	
COMPANY; METLIFE GROUP, INC.; MET	)	
LIFE, INC.; and JOHN DOE,	)	
	)	
Defendants.	)	

TO: METROPOLITAN LIFE INSURANCE COMPANY, Defendant.  
200 Park Avenue  
New York, NY 10166

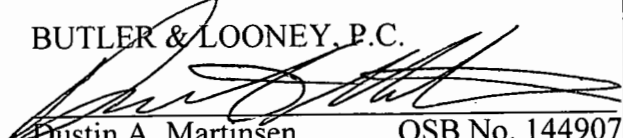
IN THE NAME OF THE STATE OF OREGON: You are hereby required to appear and defend the complaint filed against you in the above-entitled cause within 30 days from the date of service of this summons on you; and if you fail to appear, Plaintiff will apply to the court for the relief demanded in the complaint.

NOTICE TO DEFENDANT: READ THESE PAPERS CAREFULLY!

You must "appear" in this case or the other side will win automatically. To "appear" you must file with the court a legal paper called a "motion" or "answer." The "motion" or "answer" must be given to the court clerk or administrator within 30 days, along with the required filing fee. It must be in proper form and have proof of service on Plaintiff's attorney or, if Plaintiff does not have an attorney, proof of service on Plaintiff.

IF YOU HAVE ANY QUESTIONS, YOU SHOULD SEE AN ATTORNEY IMMEDIATELY. If you need help in finding an attorney, you may call the Oregon State Bar's Lawyer Referral Service at (503) 684-3763 or toll-free in Oregon at (800) 452-7636.

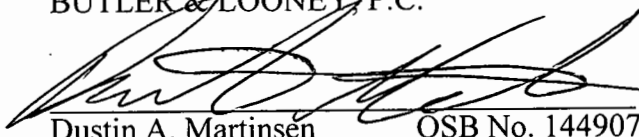
BUTLER & LOONEY, P.C.

  
Dustin A. Martinsen OSB No. 144907  
Attorney for Plaintiff  
PO Box 430 – 292 Main St. South  
Vale, Oregon 97918  
(541) 473-3111

STATE OF OREGON )  
:ss  
County of Malheur )

I, the undersigned attorney of record for the Plaintiff, certify that the foregoing is an exact and complete copy of the original summons in the above-entitled action.

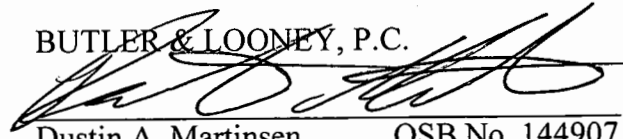
BUTLER & LOONEY, P.C.

  
Dustin A. Martinsen OSB No. 144907  
Attorney for Plaintiff

\*\*\*\*\*

TO THE OFFICER OR OTHER PERSON SERVING THIS SUMMONS: You are hereby directed to serve a true copy of this summons, together with a true copy of the complaint mentioned therein, on the defendant, and to make your proof of service on a separate similar document which you shall attach hereto.

BUTLER & LOONEY, P.C.

  
Dustin A. Martinsen OSB No. 144907  
Attorney for Plaintiff

BUTLER &  
LOONEY, P.C.  
PO BOX 430  
VALE OR 97918  
(541) 473-3111

5/16/2018 3:23 PM  
18CV19798

CERTIFIED A  
TRUE COPY  
OF ATTORNEYS FOR  
Plaintiffs

IN THE CIRCUIT COURT STATE OF OREGON  
FOR THE COUNTY OF UMATILLA

BRADLEY D. ZIMMER,

Plaintiff,

vs.

METROPOLITAN LIFE  
INSURANCE COMPANY; METLIFE  
GROUP, INC.; MET LIFE, INC.; and  
JOHN DOE

Defendant.

Case No. 18CV19798

COMPLAINT

Filing Fee Pursuant to ORS 21.160(1)(c)  
Claimed Amount \$50,000.00 to \$1 million  
Filing Fee: \$560.00

Plaintiff, Bradley D. Zimmer, appears by and through his attorney of record, Dustin A. Martinsen, and makes the following allegations and complaint against the above captioned Defendant.

GENERAL ALLEGATIONS

1.

Bradley D. Zimmer, procured a policy of disability income insurance: Long term benefit from Metropolitan Life Insurance Company, Metlife Group, Inc., or John Doe (likely a subsidiary of Metropolitan Life Insurance Company).

2.

The policy was a group plan. The policy included coverage for alcohol and drug addiction as well as mental disorders that prevented the insured from working at full capacity in the job/industry he was accustomed to.

3.

Plaintiff did make the required payments under the policy for the duration of the policy.

4.

Plaintiff has been a resident of the State of Oregon for all relevant time periods.

5.

Defendant(s) have conducted significant business within the State of Oregon for all relevant time periods and events.

6.

This court has both personal and subject matter jurisdiction over this matter.

FIRST CAUSE OF ACTION

Declaratory Judgment

7.

Plaintiff realleges and hereby incorporates paragraphs 1 through 6.

8.

Plaintiff was diagnosed Bi-Polar Disorder in 2011.

9.

Plaintiff did suffer a series of traumatic events in 2014 that led to a diagnosis of Post Traumatic Stress Disorder.

10.

Over the course of Plaintiff's life, he has suffered numerous head injuries that led to a diagnosis of Traumatic Brain Injury.

11.

On May 14, 2015, Bradley D. Zimmer's treating physician stated, "Should stop work to help reduce stress and protect client."

///

///

12.

Physician's May 14, 2015, statement affirmed Mr. Zimmer's feelings of disability and inability to adequately work in his field.

13.

The policy defines "totally disabled" or "total disability" as "in the elimination period in the next 24 months, you are unable to perform with reasonable continuity the substantial and material acts necessary to pursue your usual occupation in the usual and customary way."

14.

Due to Plaintiff's disability, he was unable to perform substantial and material acts necessary to pursue his usual occupation of running an insurance agency for a period of at least 24 months.

15.

Plaintiff is entitled to the following declaratory judgment:

(1) That Plaintiff had an active insurance policy, through Defendant's company, for all relevant time periods;

(2) Plaintiff was determined by a qualified physician to be unable to assist clients;

(3) That Plaintiff did make claim upon Defendant insurance company and was denied;

(4) The insurance policy covers disability from mental illness; and

(5) Plaintiff is entitled to the coverage provisions of his insurance policy.

## SECOND CAUSE OF ACTION

### Breach of Contract

16.

Plaintiff realleges and hereby incorporates paragraphs 1 through 15.

17.

Upon information and belief, Plaintiff alleges that Exhibit "1" contains relevant provisions to his long-term disability contract with Metropolitan Life Insurance Company.

Page 3 of 5 – COMPLAINT

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18.

Plaintiff made an initial claim for disability insurance with the Defendant, on or about May 18, 2015.

19.

Defendant, Metropolitan Life Insurance Company, denied coverage to Plaintiff.

20.

Plaintiff appealed Defendant's decision.

21.

Defendant, Metropolitan Life Insurance Company, denied Plaintiff's appeal.

22.

Plaintiff's long-term disability payments were limited to two years pursuant to the Contract.

23.

Defendant, Metropolitan Life Insurance Company, does owe Plaintiff for two years of disability payments from May 1, 2015, until May 1, 2017.

24.

Defendant has failed to make any payments to Plaintiff under the policy. Defendant has been provided with medical documentation evidencing the mental disability of the Plaintiff.

25.

Defendant has been provided with medical documentation that indicates Plaintiff "should stop work to help reduce stress, and protect clients."

WHEREFORE Plaintiff seeks the following remedies from this Court:

1.

For declaratory judgment that:

a) Plaintiff did have a long-term disability insurance policy with Defendant as the insurer;

Page 4 of 5 – COMPLAINT

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- 1 b) That Defendant was advised by a medical doctor that due to his mental disorders he  
2 should stop working for his own protection and for that of his clients;  
3 c) That Defendant acted reasonably in following instructions given him by his physician;  
4 d) That Plaintiff had an active insurance policy, through Defendant's company, for all  
5 relevant time periods;  
6 e) Plaintiff was determined by a qualified physician to be unable to assist clients and  
7 should stop working;  
8 f) That Plaintiff did make claim upon Defendant insurance company and was denied;  
9 g) That Defendant acted reasonably in following instructions given him by his physician;  
10 h) The insurance policy covers disability from mental illness; and  
11 i) Plaintiff is entitled to the coverage provisions of his insurance policy.

12 2.

13 That Defendant is in breach of its contractual obligations;

14 3.

15 That Defendant owes Plaintiff contractual obligations, in an amount to be proven at trial;

16 and

17 4.

18 Plaintiff is also entitled to attorney's fees pursuant to ORS 742.061, and any other  
19 applicable Oregon statute or case law.

20 Date: May 16, 2018

21 BUTLER & LOONEY, P.C.

22 By:   
23

24 Dustin A. Martinsen, OSB No. 144907  
25 Attorney for Plaintiff  
26

## **YOUR BENEFIT PLAN**

### **Farmers® Agents' Group Benefits Program**

**All Active Full-Time Agents and District Managers  
Who Have An Appointment Agreement With Farmers Insurance  
Exchange In Active Appointment**

**Disability Income Insurance: Long Term Benefits**

**Certificate Date: January 1, 2014**

**Certificate Number 28**

EXHIBIT 1 - 1

Farmers® Agents' Group Benefits Program  
4680 Wilshire Boulevard  
Los Angeles, CA 90010

**TO OUR PARTICIPANTS:**

All of us appreciate the protection and security insurance provides.

This certificate describes the benefits that are available to you. We urge you to read it carefully.

Farmers® Agents' Group Benefits Program



Metropolitan Life Insurance Company  
200 Park Avenue, New York, New York 10166

## **CERTIFICATE OF INSURANCE**

Metropolitan Life Insurance Company ("MetLife"), a stock company, certifies that You are insured for the benefits described in this certificate, subject to the provisions of this certificate. This certificate is issued to You under the Group Policy and it includes the terms and provisions of the Group Policy that describe Your insurance. **PLEASE READ THIS CERTIFICATE CAREFULLY.**

This certificate is part of the Group Policy. The Group Policy is a contract between MetLife and the Plan Sponsor and may be changed or ended without Your consent or notice to You.

<b>Plan Sponsor:</b>	Farmers® Agents' Group Benefits Program
<b>Group Policy Number:</b>	110031-1-G
<b>Type of Insurance:</b>	Disability Income Insurance: Long Term Benefits
<b>MetLife Toll Free Number(s): For Claim Information</b>	FOR DISABILITY INCOME CLAIMS: 1-800-300-4296

**PLEASE AFFIX THE STICKER  
SHOWING THE PARTICIPANT'S  
NAME AND EFFECTIVE DATE  
IN THIS SPACE.**

**THIS CERTIFICATE ONLY DESCRIBES DISABILITY INSURANCE.**

**THE BENEFITS OF THE POLICY PROVIDING YOU COVERAGE ARE GOVERNED PRIMARILY BY THE  
LAWS OF A STATE OTHER THAN FLORIDA.**

**THE GROUP INSURANCE POLICY PROVIDING COVERAGE UNDER THIS CERTIFICATE WAS ISSUED  
IN A JURISDICTION OTHER THAN MARYLAND AND MAY NOT PROVIDE ALL THE BENEFITS  
REQUIRED BY MARYLAND LAW.**

**WE ARE REQUIRED BY STATE LAW TO INCLUDE THE NOTICE(S) WHICH APPEAR ON THIS PAGE  
AND IN THE NOTICE(S) SECTION WHICH FOLLOWS THIS PAGE. PLEASE READ THE(SE) NOTICE(S)  
CAREFULLY.**

**For Texas Residents:**

**IMPORTANT NOTICE**

To obtain information or make a complaint:

You may call MetLife's toll free telephone number for information or to make a complaint at

1-800-300-4296

You may contact the Texas Department of Insurance to obtain information on companies, coverages, rights or complaints at

1-800-252-3439

You may write the Texas Department of Insurance

P.O. Box 149104

Austin, TX 78714-9104

Fax # (512) 475-1771

Web: <http://www.tdi.state.tx.us>

Email: [ConsumerProtection@tdi.state.tx.us](mailto:ConsumerProtection@tdi.state.tx.us)

**PREMIUM OR CLAIM DISPUTES:** Should You have a dispute concerning Your premium or about a claim, You should contact MetLife first. If the dispute is not resolved, You may contact the Texas Department of Insurance.

**ATTACH THIS NOTICE TO YOUR CERTIFICATE:**

This notice is for information only and does not become a part or condition of the attached document.

**Para Residentes de Texas:**

**AVISO IMPORTANTE**

Para obtener información o para someter una queja:

Usted puede llamar al número de teléfono gratis de MetLife para información o para someter una queja al

1-800-300-4296

Puede comunicarse con el Departamento de Seguros de Texas para obtener información acerca de compañías, coberturas, derechos o quejas al

1-800-252-3439

Puede escribir al Departamento de Seguros de Texas

P.O. Box 149104

Austin, TX 78714-9104

Fax # (512) 475-1771

Web: <http://www.tdi.state.tx.us>

Email: [ConsumerProtection@tdi.state.tx.us](mailto:ConsumerProtection@tdi.state.tx.us)

**DISPUTAS SOBRE PRIMAS O RECLAMOS:** Si tiene una disputa concerniente a su prima o a un reclamo, debe comunicarse con MetLife primero. Si no se resuelve la disputa, puede entonces comunicarse con el departamento (TDI).

**UNA ESTE AVISO A SU CERTIFICADO:**

Este aviso es solo para propósito de información y no se convierte en parte o condición del documento adjunto.

## **NOTICE FOR RESIDENTS OF ALL STATES**

### **WORKERS' COMPENSATION**

This certificate does not replace or affect any requirement for coverage by workers' compensation insurance.

### **MANDATORY DISABILITY INCOME BENEFIT LAWS**

**For Residents of California, Hawaii, New Jersey, New York, Rhode Island and Puerto Rico**

This certificate does not affect any requirement for any government mandated temporary disability income benefits law.

**NOTICE FOR RESIDENTS OF ARKANSAS**

If You have a question concerning Your coverage or a claim, first contact the Policyholder or group account administrator. If, after doing so, You still have a concern, You may call the toll free telephone number shown on the Certificate Face Page.

If You are still concerned after contacting both the Policyholder and MetLife, You should feel free to contact:

Arkansas Insurance Department  
Consumer Services Division  
1200 West Third Street  
Little Rock, Arkansas 72201  
(501) 371-2640 or (800) 852-5494

**NOTICE FOR RESIDENTS OF CALIFORNIA**

**IMPORTANT NOTICE**

**TO OBTAIN ADDITIONAL INFORMATION, OR TO MAKE A COMPLAINT, CONTACT THE POLICYHOLDER OR THE METLIFE CLAIM OFFICE SHOWN ON THE EXPLANATION OF BENEFITS YOU RECEIVE AFTER FILING A CLAIM.**

**IF, AFTER CONTACTING THE POLICYHOLDER AND/OR METLIFE, YOU FEEL THAT A SATISFACTORY SOLUTION HAS NOT BEEN REACHED, YOU MAY FILE A COMPLAINT WITH THE CALIFORNIA INSURANCE DEPARTMENT AT:**

**DEPARTMENT OF INSURANCE  
300 SOUTH SPRING STREET  
LOS ANGELES, CA 90013  
1 (800) 927-4357**

## **NOTICE FOR RESIDENTS OF GEORGIA**

### **IMPORTANT NOTICE**

The laws of the state of Georgia prohibit insurers from unfairly discriminating against any person based upon his or her status as a victim of family violence.

## **NOTICE FOR RESIDENTS OF IDAHO**

If You have a question concerning Your coverage or a claim, first contact the Policyholder. If, after doing so, You still have a concern, You may call the toll free telephone number shown on the Certificate Face Page.

If You are still concerned after contacting both the Policyholder and MetLife, You should feel free to contact:

Idaho Department of Insurance  
Consumer Affairs  
700 West State Street, 3<sup>rd</sup> Floor  
PO Box 83720  
Boise, Idaho 83720-0043  
1-800-721-3272 or [www.DOI.Idaho.gov](http://www.DOI.Idaho.gov)

**NOTICE FOR RESIDENTS OF ILLINOIS**

**IMPORTANT NOTICE**

To make a complaint to MetLife, You may write to:

MetLife  
200 Park Avenue  
New York, New York 10166

The address of the Illinois Department of Insurance is:

Illinois Department of Insurance  
Public Services Division  
Springfield, Illinois 62767

## **NOTICE FOR RESIDENTS OF INDIANA**

**Questions regarding your policy or coverage should be directed to:**

**Metropolitan Life Insurance Company  
1-800-638-6420**

**If you (a) need the assistance of the government agency that regulates insurance; or (b) have a complaint you have been unable to resolve with your insurer you may contact the Department of Insurance by mail, telephone or email:**

**State of Indiana Department of Insurance  
Consumer Services Division  
311 West Washington Street, Suite 300  
Indianapolis, Indiana 46204**

**Consumer Hotline: (800) 622-4461; (317) 232-2395**

**Complaint can be filed electronically at [www.in.gov/doi](http://www.in.gov/doi)**

## **NOTICE FOR MASSACHUSETTS RESIDENTS**

### **CONTINUATION OF DISABILITY INCOME INSURANCE**

1. If Your Disability Income Insurance ends due to a Plant Closing or Covered Partial Closing, such insurance will be continued for 90 days after the date it ends.
2. If Your Disability Income Insurance ends because:
  - You cease to be in an Eligible Class; or
  - Your employment terminates;

for any reason other than a Plant Closing or Covered Partial Closing, such insurance will continue for 31 days after the date it ends.

Continuation of Your Disability Income Insurance under the CONTINUATION OF INSURANCE WITH PREMIUM PAYMENT subsection will end before the end of continuation periods shown above if You become covered for similar benefits under another plan.

**Plant Closing and Covered Partial Closing** have the meaning set forth in Massachusetts Annotated Laws, Chapter 151A, Section 71A.

**NOTICE FOR RESIDENTS OF NORTH CAROLINA**

**Read your Certificate Carefully.**

**This Certificate Contains a Pre-existing Condition Limitation.**

**IMPORTANT CANCELLATION INFORMATION**

**Please Read The Provision Entitled**

**DATE YOUR INSURANCE ENDS**

**Found on Pages e/ee**

## **NOTICE FOR RESIDENTS OF NORTH CAROLINA**

UNDER NORTH CAROLINA GENERAL STATUTE SECTION 58-50-40, NO PERSON, EMPLOYER, PRINCIPAL, AGENT, TRUSTEE, OR THIRD PARTY ADMINISTRATOR, WHO IS RESPONSIBLE FOR THE PAYMENT OF GROUP HEALTH OR LIFE INSURANCE OR GROUP HEALTH PLAN PREMIUMS, SHALL:

- (1) CAUSE THE CANCELLATION OR NONRENEWAL OF GROUP HEALTH OR LIFE INSURANCE, HOSPITAL, MEDICAL, OR DENTAL SERVICE CORPORATION PLAN, MULTIPLE EMPLOYER WELFARE ARRANGEMENT, OR GROUP HEALTH PLAN COVERAGES AND THE CONSEQUENTIAL LOSS OF THE COVERAGES OF THE PERSONS INSURED, BY WILLFULLY FAILING TO PAY THOSE PREMIUMS IN ACCORDANCE WITH THE TERMS OF THE INSURANCE OR PLAN CONTRACT, AND
- (2) WILLFULLY FAIL TO DELIVER, AT LEAST 45 DAYS BEFORE THE TERMINATION OF THOSE COVERAGES, TO ALL PERSONS COVERED BY THE GROUP POLICY A WRITTEN NOTICE OF THE PERSON'S INTENTION TO STOP PAYMENT OF PREMIUMS. THIS WRITTEN NOTICE MUST ALSO CONTAIN A NOTICE TO ALL PERSONS COVERED BY THE GROUP POLICY OF THEIR RIGHTS TO HEALTH INSURANCE CONVERSION POLICIES UNDER ARTICLE 53 OF CHAPTER 58 OF THE GENERAL STATUTES AND THEIR RIGHTS TO PURCHASE INDIVIDUAL POLICIES UNDER THE FEDERAL HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT AND UNDER ARTICLE 68 OF CHAPTER 58 OF THE GENERAL STATUTES.

VIOLATION OF THIS LAW IS A FELONY. ANY PERSON VIOLATING THIS LAW IS ALSO SUBJECT TO A COURT ORDER REQUIRING THE PERSON TO COMPENSATE PERSONS INSURED FOR EXPENSES OR LOSSES INCURRED AS A RESULT OF THE TERMINATION OF THE INSURANCE.

## NOTICE FOR RESIDENTS OF UTAH

### Notice of Protection Provided by Utah Life and Health Insurance Guaranty Association

This notice provides a brief summary of the Utah Life and Health Insurance Guaranty Association ("the Association") and the protection it provides for policyholders. This safety net was created under Utah law, which determines who and what is covered and the amounts of coverage.

The Association was established to provide protection in the unlikely event that your life, health, or annuity insurance company becomes financially unable to meet its obligations and is taken over by its insurance regulatory agency. If this should happen, the Association will typically arrange to continue coverage and pay claims, in accordance with Utah law, with funding from assessments paid by other insurance companies.

The basic protections provided by the Association are:

- Life Insurance
  - o \$500,000 in death benefits
  - o \$200,000 in cash surrender or withdrawal values
- Health Insurance
  - o \$500,000 in hospital, medical and surgical insurance benefits
  - o \$500,000 in long-term care insurance benefits
  - o \$500,000 in disability income insurance benefits
  - o \$500,000 in other types of health insurance benefits
- Annuities
  - o \$250,000 in withdrawal and cash values

The maximum amount of protection for each individual, regardless of the number of policies or contracts, is \$500,000. Special rules may apply with regard to hospital, medical and surgical insurance benefits.

**Note: Certain policies and contracts may not be covered or fully covered.** For example, coverage does not extend to any portion of a policy or contract that the insurer does not guarantee, such as certain investment additions to the account value of a variable life insurance policy or a variable annuity contract. Coverage is conditioned on residency in this state and there are substantial limitations and exclusions. For a complete description of coverage, consult Utah Code, Title 31A, Chapter 28.

Insurance companies and agents are prohibited by Utah law to use the existence of the Association or its coverage to encourage you to purchase insurance. When selecting an insurance company, you should not rely on Association coverage. If there is any inconsistency between Utah law and this notice, Utah law will control.

To learn more about the above protections, as well as protections relating to group contracts or retirement plans, please visit the Association's website at [www.utlifega.org](http://www.utlifega.org) or contact:

Utah Life and Health Insurance Guaranty Assoc.  
60 East South Temple, Suite 500  
Salt Lake City UT 84111  
(801) 320-9955

Utah Insurance Department  
3110 State Office Building  
Salt Lake City UT 84114-6901  
(801) 538-3800

A written complaint about misuse of this Notice or the improper use of the existence of the Association may be filed with the Utah Insurance Department at the above address.

## **NOTICE FOR RESIDENTS OF VIRGINIA**

### **IMPORTANT INFORMATION REGARDING YOUR INSURANCE**

In the event You need to contact someone about this insurance for any reason please contact Your agent. If no agent was involved in the sale of this insurance, or if You have additional questions You may contact the insurance company issuing this insurance at the following address and telephone number:

MetLife  
200 Park Avenue  
New York, New York 10166  
Attn: Corporate Consumer Relations Department

To phone in a claim related question, You may call Claims Customer Service at:  
1-800-275-4638

If You have been unable to contact or obtain satisfaction from the company or the agent, You may contact the Virginia State Corporation Commission's Bureau of Insurance at:

The Office of the Managed Care Ombudsman  
Bureau of Insurance  
P.O. Box 1157  
Richmond, VA 23218  
1-877-310-6560 - toll-free  
1-804-371-9691 - locally  
[www.scc.virginia.gov](http://www.scc.virginia.gov) - web address  
[ombudsman@scc.virginia.gov](mailto:ombudsman@scc.virginia.gov) - email

**NOTICE FOR RESIDENTS OF WISCONSIN**

**KEEP THIS NOTICE WITH YOUR INSURANCE PAPERS**

**PROBLEMS WITH YOUR INSURANCE?** - If You are having problems with Your insurance company or agent, do not hesitate to contact the insurance company or agent to resolve Your problem.

MetLife  
Attn: Corporate Consumer Relations Department  
200 Park Avenue  
New York, NY 10166-0188  
1-800-638-5433

You can also contact the **OFFICE OF THE COMMISSIONER OF INSURANCE**, a state agency which enforces Wisconsin's insurance laws, and file a complaint. You can contact the **OFFICE OF THE COMMISSIONER OF INSURANCE** by contacting:

Office of the Commissioner of Insurance  
Complaints Department  
P.O. Box 7873  
Madison, WI 53707-7873  
1-800-236-8517 outside of Madison or 608-266-0103 in Madison.

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**SCHEDULE OF BENEFITS**

This schedule shows the benefits that are available under the Group Policy. You will only be insured for the benefits:

- for which You become and remain eligible;
- which You elect, if subject to election; and
- which are in effect.

**BENEFIT****BENEFIT AMOUNT AND HIGHLIGHTS****Disability Income Insurance For You: Long Term Benefits****For Class 1:**

Monthly Benefit.....	\$1,250, subject to the INCOME WHICH WILL REDUCE YOUR DISABILITY BENEFIT section.
Maximum Monthly Benefit.....	66 2/3% of Your Predisability Earnings
Minimum Monthly Benefit.....	10% of the Monthly Benefit before reductions for Other Income Benefits or \$100, whichever is greater, subject to the Overpayments and Rehabilitation Incentive subsections of this certificate
Elimination Period.....	180 Days

**For Class 2:**

Monthly Benefit.....	50.00% of the first \$20,000 of Your Predisability Earnings, subject to the INCOME WHICH WILL REDUCE YOUR DISABILITY BENEFIT section
Maximum Monthly Benefit.....	\$10,000
Minimum Monthly Benefit.....	10% of the Monthly Benefit before reductions for Other Income Benefits or \$100, whichever is greater, subject to the Overpayments and Rehabilitation Incentive subsections of this certificate
Elimination Period.....	Option 1: 180 Days Option 2: 90 Days

**SCHEDULE OF BENEFITS (continued)****Class 1 and 2:****Maximum Benefit Period\***

the period shown below:

<b>Age on Date of Your Disability</b>	<b>Benefit Period</b>
Less than 60	To age 65
60	60 months
61	48 months
62	42 months
63	36 months
64	30 months
65	24 months
66	21 months
67	18 months
68	15 months
69 and over	12 months

\*The Maximum Benefit Period is subject to the LIMITED DISABILITY BENEFITS and DATE BENEFIT PAYMENTS END sections.

Rehabilitation Incentives..... Yes

**Additional Benefits:**

Single Sum Payment in the Event of Your Death..... Yes

Benefit(s) in the Event of Your Terminal Illness..... Yes

Portability ..... Yes

## DEFINITIONS

As used in this certificate, the terms listed below will have the meanings set forth below. When defined terms are used in this certificate, they will appear with initial capitalization. The plural use of a term defined in the singular will share the same meaning.

**Actively at Work or Active Work** means that You are performing all of the usual and customary duties of Your job on a Full-Time basis. This must be done at:

- the Plan Sponsor's place of business;
- an alternate place approved by the Plan Sponsor; or
- a place to which the Plan Sponsor's business requires You to travel.

You will be deemed to be Actively at Work during weekends or Plan Sponsor approved vacations, holidays or business closures if You were Actively at Work on the last scheduled work day preceding such time off.

**Beneficiary** means the person(s) to whom We will pay insurance as determined in accordance with the GENERAL PROVISIONS section.

**Consumer Price Index** means the CPI-W, the Consumer Price Index for Urban Wage Earners and Clerical Workers published by the U.S. Department of Labor. If the CPI-W is discontinued or replaced, We reserve the right to substitute any other comparable index.

**Contributory Insurance** means insurance for which the Plan Sponsor requires You to pay any part of the premium.

Contributory Insurance includes: Disability Income Insurance; Long Term Benefits.

**Disability or Disabled** The definition of "Disability or Disabled" is outlined on a separate page which can be found at the end of the Definitions section.

**Domestic Partner** means each of two people who are of the same or opposite sex, one of whom is a participant of the Plan Sponsor and who represent themselves publicly as each other's domestic partner and have:

1. registered as domestic partners or members of a civil union with a government agency or office where such registration is available; or
2. submitted a domestic partner declaration to the Plan Sponsor.

The Domestic Partner declaration must be signed by both parties, and establish that:

- each person is 18 years of age or older;
- neither person is married;
- neither person has had another Domestic Partner within 6 months prior to the enrollment date for insurance for the Domestic Partner under the Group Policy;
- they have shared the same residence for at least 6 months prior to the date they enroll for insurance for the Domestic Partner under the Group Policy;
- they are not related by blood in a manner that would bar their marriage in the jurisdiction in which they reside; and
- they have an exclusive mutual commitment to share the responsibility for each other's welfare and financial obligations which commitment existed for at least 6 months prior to the date they enroll for insurance for the Domestic Partner under the Group Policy, and such commitment is expected to last indefinitely.

## **DEFINITIONS (continued)**

2 or more of the following exist as evidence of joint responsibility for basic financial obligations:

- a joint mortgage or lease;
- designation of the Domestic Partner as beneficiary for life insurance or retirement benefits;
- joint wills or designation of the Domestic Partner as executor and/or primary beneficiary;
- designation of the Domestic Partner as durable power of attorney or health care proxy;
- ownership of a joint bank account, joint credit cards or other evidence of joint financial responsibility; or
- other evidence of economic interdependence.

For purposes of determining who may become a Covered Person, the term does not include any person who:

- is in the military of any country or subdivision of a country;
- is insured under the Group Policy as a participant.

**Elimination Period** means the period of Your Disability during which We do not pay benefits. The Elimination Period begins on the day You become Disabled and continues for the period shown in the SCHEDULE OF BENEFITS.

**Full-Time** means Active Work of at least 20 hours per week on the Plan Sponsor's regular work schedule for the eligible class of participants to which You belong.

**Physician** means:

- a person licensed to practice medicine in the jurisdiction where such services are performed; or
- any other person whose services, according to applicable law, must be treated as Physician's services for purposes of the Group Policy. Each such person must be licensed in the jurisdiction where he performs the service and must act within the scope of that license. He must also be certified and/or registered if required by such jurisdiction.

**The term does not include:**

- You;
- Your Spouse or Domestic Partner; or
- any member of Your immediate family including Your and/or Your Spouse's or Domestic Partner's:
  - parents;
  - children (natural, step or adopted);
  - siblings;
  - grandparents; or
  - grandchildren.

**Plan Sponsor's Retirement Plan** means a plan which:

- provides retirement benefits to participants; and
- is funded in whole or in part by Plan Sponsor contributions.

**The term does not include:**

- profit sharing plans;
- thrift or savings plans;

**DEFINITIONS (continued)**

- non-qualified plans of deferred compensation;
- plans under IRC Section 401(k) or 457;
- individual retirement accounts (IRA);
- tax sheltered annuities (TSA) under IRC Section 403(b);
- stock ownership plans; or
- Keogh (HR-10) plans.

**Predisability Earnings** means Your monthly commissions received from the Plan Sponsor in effect just prior to Your date of Disability. Monthly commissions means Your commissions, including bonuses, less eligible folio deductions, but not including any agent/district manager authorized folio deductions payable to third parties. Monthly commissions (i.e. 1099 income) are reported on the electronic commissions statement provided by the Plan Sponsor as "gross commissions". "Gross commissions" = "sub total" + "value added" + "FFS" less "deferred auto NB commissions."

Commissions will be averaged over the lesser of:

- the full 12 month-calendar period of the participant's agreement with their Plan Sponsor; or
- the period of the actual agreement with the participant's Plan Sponsor.

**Proof** means Written evidence satisfactory to Us that a person has satisfied the conditions and requirements for any benefit described in this certificate. When a claim is made for any benefit described in this certificate, Proof must establish:

- the nature and extent of the loss or condition;
- Our obligation to pay the claim; and
- the claimant's right to receive payment.

Proof must be provided at the claimant's expense.

**Rehabilitation Program** means a program that has been approved by us for the purpose of helping You return to work. It may include, but is not limited to, Your participation in one or more of the following activities:

- return to work on a modified basis with a goal of resuming employment for which You are reasonably qualified by training, education, experience and past earnings;
- on-site job analysis;
- job modification/accommodation;
- training to improve job-seeking skills;
- vocational assessment;
- short-term skills enhancement;
- vocational training; or
- restorative therapies to improve functional capacity to return to work.

**Sickness** means illness, disease or pregnancy, including complications of pregnancy.

**Signed** means any symbol or method executed or adopted by a person with the present intention to authenticate a record, which is on or transmitted by paper or electronic media which is acceptable to Us and consistent with applicable law.

**Spouse** means Your lawful spouse.

**DEFINITIONS (continued)**

**We, Us and Our** mean MetLife.

**Written or Writing** means a record which is on or transmitted by paper or electronic media which is acceptable to Us and consistent with applicable law.

**You and Your** mean a participant who is insured under the Group Policy for the insurance described in this certificate.

**DEFINITIONS (continued)**

**Disability or Disabled** means that as a result of Sickness or injury You are either Totally Disabled or Partially Disabled.

**Totally Disabled or Total Disability** means:

During the Elimination Period and the next 24 months, You are unable to perform with reasonable continuity the Substantial and Material Acts necessary to pursue Your Usual Occupation in the usual and customary way.

After such period, You are not able to engage with reasonable continuity in any occupation in which You could reasonably be expected to perform satisfactorily in light of Your:

- age;
- education;
- training;
- experience;
- station in life; and
- physical and mental capacity

that exists within any of the following locations:

- a reasonable distance or travel time from Your residence in light of the commuting practices of Your community;
- a distance of travel time equivalent to the distance or travel time You traveled to work before becoming disabled; or
- the regional labor market, if You reside or resided prior to becoming disabled in a metropolitan area.

**Partially Disabled or Partial Disability** means while actually working in an occupation, You are unable to earn 80% or more of Your Predisability Earnings.

If You are Partially Disabled and have received a Monthly Benefit for 24 months, We will adjust Your Predisability Earnings only for the purposes of determining whether You continue to be Partially Disabled and for calculating the Return to Work Incentive, if any. We will make the initial adjustment as follows:

We will add to Your Predisability Earnings an amount equal to the product of:

- Your Predisability Earnings times
- the annual rate of increase in the Consumer Price Index for the prior calendar year.

Annually thereafter, We will add an amount to Your adjusted Predisability Earnings calculated by the method set forth above but substituting Your adjusted Predisability Earnings from the prior year for Your Predisability Earnings. This adjustment is not a cost of living benefit.

For purposes of determining whether a Disability is the direct result of an injury, the Disability must have occurred within 90 days of the injury and not as a result of Sickness.

If Your occupation requires a license, the fact that You lose Your license for any reason will not, in itself, constitute Disability.

**Substantial and Material Acts** means the important tasks, functions and operations generally required by employers from those engaged in Your Usual Occupation that cannot be reasonably omitted or modified. In determining what substantial and material acts are necessary to pursue Your Usual Occupation, We will first

**DEFINITIONS (continued)**

look at the specific duties required by Your job. If You are unable to perform one or more of these duties with reasonable continuity, We will then determine whether those duties are customarily required of other employees engaged in Your Usual Occupation. If any specific, material duties required of You by Your job differ from the material duties customarily required of other employees engaged in Your Usual Occupation, then We will not consider those duties in determining what substantial and material acts are necessary to pursue Your Usual Occupation.

**Usual Occupation** means any employment, business, trade or profession and the Substantial and Material Acts of the occupation You were regularly performing for the Plan Sponsor when the Disability began. Usual Occupation is not necessarily limited to the specific job that You performed for the Plan Sponsor.

## **ELIGIBILITY PROVISIONS: INSURANCE FOR YOU**

### **ELIGIBLE CLASS(ES)**

**Class 1.** All Active Full-Time Agents and District Managers who receive an appointment agreement with Farmers Insurance Exchange in active appointment on or after January 1, 2014 and whose active appointment duration is less than three years.

**Class 2.** All Active Full-Time Agents and District Managers who have an appointment agreement with Farmers Insurance Exchange in active appointment and;

- whose active appointment occurred prior to January 1, 2014; or
- whose active appointment occurred on or after January 1, 2014 and has remained active for three years.

### **DATE YOU ARE ELIGIBLE FOR INSURANCE**

You may only become eligible for the insurance available for Your eligible class as shown in the **SCHEDULE OF BENEFITS**.

If You are in an eligible class on January 1, 2014, You will be eligible for the insurance described in this certificate on that date.

If You enter an eligible class after January 1, 2014, You will be eligible for the insurance described in this certificate on the date You enter that class.

### **ENROLLMENT PROCESS**

If You are eligible for insurance, You may enroll for such insurance by completing the required form. If You enroll for Contributory Insurance, You must also give the Plan Sponsor Written permission to deduct premiums from Your pay for such insurance. You will be notified by the Plan Sponsor how much You will be required to contribute.

The insurance listed below is part of a benefits plan established by the Plan Sponsor. Subject to the rules of the benefits plan and the Group Policy, You may enroll for:

- Disability Income Insurance: Long Term Benefits;

only when You are first eligible or during an annual enrollment period. You should contact the Plan Sponsor for more information regarding the benefits plan.

### **DATE YOUR CONTRIBUTORY INSURANCE TAKES EFFECT**

#### **Enrollment When First Eligible**

If You complete the enrollment process within 31 days of becoming eligible for insurance, such insurance will take effect on the date You become eligible for such insurance if You are Actively at Work on that date.

If You do not complete the enrollment process within 31 days of becoming eligible, You will not be able to enroll for insurance until the next annual enrollment period, as determined by the Plan Sponsor, following the date You first became eligible. At that time You will be able to enroll for insurance for which You are then eligible.

If You are not Actively at Work on the date insurance would otherwise take effect, insurance will take effect on the day You resume Active Work.

**ELIGIBILITY PROVISIONS: INSURANCE FOR YOU (continued)****Enrollment During An Annual Enrollment Period**

During any annual enrollment period as determined by the Plan Sponsor, You may enroll for insurance for which You are eligible or choose a different option than the one for which You are currently enrolled. The insurance enrolled for or changes to Your insurance made during an annual enrollment period will take effect as follows:

- for any amount for which You are not required to give evidence of Your insurability, such insurance will take effect on the first day of the calendar year following the annual enrollment period, if You are Actively at Work on that date.
- for any amount for which You are required to give evidence of Your insurability and We determine that You are insurable, such insurance will take effect on the date We state in Writing, if You are Actively at Work on that date.

If You are not Actively at Work on the date an amount of insurance would otherwise take effect, that amount of insurance will take effect on the day You resume Active Work.

**DATE YOUR INSURANCE ENDS**

Your insurance will end on the earliest of:

1. the date the Group Policy ends; or
2. the date insurance ends for Your class; or
3. the end of the period for which the last premium has been paid for You; or
4. the date You cease to be in an eligible class. You will cease to be in an eligible class on the date You cease Active Work in an eligible class, if You are not disabled on that date; or
5. for Class 1, the end of the calendar year following 3 years from the date of Your appointment; or
6. the date Your appointment ends; or
7. the date You retire in accordance with the date Your appointment ends.

In certain cases insurance may be continued as stated in the section entitled CONTINUATION OF INSURANCE WITH PREMIUM PAYMENT.

**Reinstatement of Disability Income Insurance**

If Your insurance ends, You may become insured again as follows:

1. If Your insurance ends because:

- You cease to be in an eligible class; or
- Your appointment ends; and

You become a member of an eligible class again within 3 months of the date Your insurance ended, You will not have to complete a new Waiting Period or provide evidence of Your insurability.

2. If Your insurance ends because you cease making the required premium while on an approved Family and Medical Leave Act (FMLA) or other legally mandated leave of absence, and you become a member of an eligible class within 31 days of the earlier of:

- The end of the period of leave You and the Plan Sponsor agreed upon; or
- The end of the eligible leave period required under the FMLA or other similar legally mandated leave of absence law.

**ELIGIBILITY PROVISIONS: INSURANCE FOR YOU (continued)**

You will not have to complete a new Waiting Period or provide evidence of Your insurability.

3. In all other cases where Your insurance ends because the required premium for Your insurance has ceased to be paid, You will be required to provide evidence of Your insurability.

If You become insured again as described in either item 1 or 2 above, the limitation for Pre-existing Conditions will be applied as if Your insurance had remained in effect with no interruption.

## **CONTINUATION OF INSURANCE WITH PREMIUM PAYMENT**

### **FOR FAMILY AND MEDICAL LEAVE**

Certain leaves of absence may qualify for continuation of insurance under the Family and Medical Leave Act of 1993 (FMLA), or other legally mandated leave of absence or similar laws. Please contact the Plan Sponsor for information regarding such legally mandated leave of absence laws.

### **AT YOUR OPTION: PORTABILITY**

#### **For Disability Income Insurance**

For purposes of this subsection the term "Portability Eligible Disability Income Insurance" refers to Disability Income Insurance: Long Term Benefits.

You may request in Writing during the Request Period specified below to continue Your Portability Eligible Disability Income Insurance under another group policy issued by MetLife if such insurance ends because You cease to be in an eligible class or Your appointment ends.

If You make a request under this subsection, evidence of Your insurability will not be required. We will issue a new certificate of insurance which will explain Your new insurance benefits. Your insurance benefits under the new certificate may not be the same as those that ended under the Group Policy.

A request under this subsection may be made, if, on the date of Your request, the following requirements are met:

- the Group Policy is in effect;
- We have not received notice from the Plan Sponsor of its intent to end the Group Policy;
- You reside in a jurisdiction that permits portability;
- You have been insured for at least 12 months prior to the date that Your appointment ends;
- Your appointment did not end as a result of Your retirement;
- You are not Disabled; and
- You have not become insured under any other disability insurance plan within 31 days after the date Your Portability Eligible Disability Income Insurance ends under the Group Policy.

#### **Request Period**

To continue Your Portability Eligible Disability Income Insurance under a different group policy, We must receive a completed request form from You within 31 days after the date such insurance ends under this certificate.

Your new certificate will take effect on the day after Your Portability Eligible Disability Income Insurance ends under this Certificate.

#### **Premiums for the New Certificate**

When You request to continue Portability Eligible Disability Income Insurance under this subsection, the first premium must be paid within 31 days after Your insurance ends under this certificate. All premiums must be paid directly to Us. When We issue the new certificate, We will also provide You with a schedule of premiums and payment instructions.

### **AT THE PLAN SPONSOR'S OPTION**

The Plan Sponsor has elected to continue insurance by paying premiums for participants who are not Disabled and cease Active Work in an eligible class for any of the reasons specified below.

## **CONTINUATION OF INSURANCE WITH PREMIUM PAYMENT (continued)**

Disability Income Insurance will continue for the following periods:

1. for the period You cease Active Work in an eligible class due to injury or sickness, up to 60 months;
2. for Disability Income Insurance: Long Term Benefits, for the period You cease Active Work in an eligible class due to any other Plan Sponsor approved leave of absence up to 60 months.

At the end of any of the continuation periods listed above, Your insurance will be affected as follows:

- if You resume Active Work in an eligible class at this time, You will continue to be insured under the Group Policy;
- if You do not resume Active Work in an eligible class at this time, Your appointment will be considered to end and Your insurance will end in accordance with the DATE YOUR INSURANCE ENDS subsection of the section entitled ELIGIBILITY PROVISIONS: INSURANCE FOR YOU.

## **EVIDENCE OF INSURABILITY**

We require evidence of insurability satisfactory to Us as follows:

1. if You make a late request for Disability Income Insurance: Long Term Benefits. A late request is one made after You were first eligible to enroll for Disability Income Insurance: Long Term Benefits.

If You do not give Us evidence of insurability or the evidence of insurability is not accepted by Us as satisfactory, You will not be covered for Disability Income Insurance: Long Term Benefits.

The evidence of insurability is to be given at Your expense.

## **DISABILITY INCOME INSURANCE: LONG TERM BENEFITS**

If You become Disabled while insured, Proof of Disability must be sent to Us. When We receive such Proof, We will review the claim. If We approve the claim, We will pay the Monthly Benefit up to the Maximum Benefit Period shown in the SCHEDULE OF BENEFITS, subject to the DATE BENEFIT PAYMENTS END section.

To verify that You continue to be Disabled without interruption after Our initial approval, We may periodically request that You send Us Proof that You continue to be Disabled. Such Proof may include physical exams, exams by independent medical examiners, in-home interviews or functional capacity exams, as needed.

While You are Disabled, the Monthly Benefit described in this certificate will not be affected if:

- Your insurance ends; or
- the Group Policy is amended to change the plan of benefits for Your class.

### **BENEFIT PAYMENT**

If We approve Your claim, benefits will begin to accrue on the day after the day You complete Your Elimination Period. We will pay the first Monthly Benefit one month after the date benefits begin to accrue. We will make subsequent payments monthly thereafter so long as You remain Disabled. Payment will be based on the number of days You are Disabled during each month and will be pro-rated for any partial month of Disability.

We will pay Monthly Benefits to You. If You die, We will pay the amount of any due and unpaid benefits as described in the GENERAL PROVISIONS subsection entitled Disability Income Benefit Payments: Who We Will Pay.

We will not pay benefits during any period for which You are eligible to receive Plan Sponsor paid residual commissions to the extent such commissions exceed 80% of Your Predisability Earnings. The benefit that You receive, in combination with Your Plan Sponsor paid residual commissions shall not exceed 100% of Your Predisability Earnings.

While You are receiving Monthly Benefits, You will not be required to pay premiums for the cost of any disability income insurance defined as Contributory Insurance.

### **RECOVERY FROM A DISABILITY**

If You return to Active Work, We will consider You to have recovered from Your Disability.

The provisions of this subsection will not apply if Your insurance has ended and You are eligible for coverage under another group long term disability plan.

#### **If You Return to Active Work Before Completing Your Elimination Period**

If You return to Active Work before completing Your Elimination Period for a period of 30 days or less, and then become Disabled again due to the same or related Sickness or accidental injury, We will not require You to complete a new Elimination Period. We will count those days towards the completion of Your Elimination Period.

If You return to Active Work for a period of more than 30 days, and then become Disabled again, You will have to complete a new Elimination Period.

For purposes of this provision, the term Active Work only includes those days You actually work.

**DISABILITY INCOME INSURANCE: LONG TERM BENEFITS (continued)****If You Return to Active Work After Completing Your Elimination Period**

If You return to Active Work after completing Your Elimination Period for a period of 6 months or less, and then become Disabled again due to the same or related Sickness or accidental injury, We will not require You to complete a new Elimination Period. For the purpose of determining Your benefits, We will consider such Disability to be a part of the original Disability and will use the same Predisability Earnings and apply the same terms, provisions and conditions that were used for the original Disability.

If You return to Active Work for a period of more than 6 months and then become Disabled again, You will have to complete a new Elimination Period.

For purposes of this provision, the term Active Work includes all of the continuous days which follow Your return to work for which You are not Disabled.

**REHABILITATION INCENTIVES****Rehabilitation Program Incentive**

If You participate in a Rehabilitation Program, We will increase Your Monthly Benefit by an amount equal to 10% of the Monthly Benefit. We will do so before We reduce Your Monthly Benefit by any other income.

**Work Incentive**

While You are Disabled, We encourage You to work. If You work while You are Disabled and receiving Monthly Benefits, Your Monthly Benefit will be adjusted as follows:

- Your Monthly Benefit will be increased by Your Rehabilitation Program Incentive, if any; and
- reduced by Other Income as defined in the DISABILITY INCOME INSURANCE: INCOME WHICH WILL REDUCE YOUR DISABILITY BENEFIT section.

Your Monthly Benefit as adjusted above will not be reduced by the amount You earn from working, except to the extent that such adjusted Monthly Benefit plus the amount You earn from working and the income You receive from Other Income exceeds 100% of Your Predisability Earnings as calculated in the definition of Disability.

In addition, the Minimum Monthly Benefit will not apply.

**Limit on Work Incentive**

After the first 12 months following your return to work, We will reduce Your Monthly Benefit by 50% of the amount You earn from working while Disabled.

**Family Care Incentive**

If You work or participate in a Rehabilitation Program while You are Disabled, We will reimburse You for up to \$400 for monthly expenses You incur for each family member to provide:

- care for Your or Your Spouse's child, legally adopted child, or child for whom You or Your Spouse are legal guardian and who is:
  - living with You as part of Your household;
  - dependent on You for support; and
  - under age 13.

The child care must be provided by a licensed child care provider who may not be a member of Your immediate family or living in Your residence.

- care to Your family member who is:

## **DISABILITY INCOME INSURANCE: LONG TERM BENEFITS (continued)**

- living with You as part of Your household;
- chiefly dependent on You for support; and
- incapable of independent living, regardless of age, due to mental or physical handicap as defined by applicable law.

Care to Your family member may not be provided by a member of Your immediate family.

We will make reimbursement payments to You on a monthly basis starting with the first Monthly Benefit payment until You have received 24 Monthly Benefit Payments. Payments will not be made beyond the Maximum Benefit Period. We will not reimburse You for any expenses for which You are eligible for payment from any other source. You must send Proof that You have incurred such expenses.

### **Moving Expense Incentive**

If You participate in a Rehabilitation Program while You are Disabled, We may reimburse You for expenses You incur in order to move to a new residence recommended as part of such Rehabilitation Program. Such expenses must be approved by Us in advance.

You must send Proof that You have incurred such expenses for moving.

We will not reimburse You for such expenses if they were incurred for services provided by a member of Your immediate family or someone who is living in Your residence.

## **DISABILITY INCOME INSURANCE: INCOME WHICH WILL REDUCE YOUR DISABILITY BENEFIT**

We will reduce Your Disability benefit by the amount of all Other Income that was actually paid to You for the same disability for which You are claiming benefits under this certificate. Other Income includes the following:

1. any disability benefits for You, Your Spouse or child(ren) under:
  - Federal Social Security Act;
  - Canadian Pension Plan;
  - Quebec Pension Plan;
  - Railroad Retirement Act; or
  - any similar plan or act;
2. temporary disability benefits under a workers' compensation law;
3. amounts under any other occupational disease law, Longshoremen's and Harbor Worker's Act, Maritime Doctrine of Maintenance, Wages and Cure or similar act;
4. any disability benefits under:
  - the Jones Act;
  - any state compulsory/statutory benefit law;
  - any government retirement system, including but not limited to the California State Teachers Retirement System (CalSTRS) and/or the California Public Employee Retirement System (CalPERS); or
  - the Plan Sponsor's retirement plan;
5. any retirement benefits under:
  - Federal Social Security Act;
  - Canadian Pension Plan;
  - Quebec Pension Plan;
  - Railroad Retirement Act;
  - the Plan Sponsor's retirement plan; or
  - any similar plan or act;
6. third party liability payments by judgment, settlement or otherwise (minus attorneys' fees);
7. sick pay;
8. amounts from compromise or settlement of any claim for any of the Other Income sources shown in this provision (minus attorneys' fees);
9. any salary continuation, personal time off, and annual leave pay; and/or
10. return to work earnings as set forth in the Work Incentive and Limit on Work Incentive sub-provisions, in the REHABILITATION INCENTIVES provision.

## **REDUCING YOUR DISABILITY BENEFIT BY AN ESTIMATED BENEFIT**

If We have a reasonable, good faith belief that You are entitled to disability benefits under the following sources of Other Income, You must apply for such benefits:

- Federal Social Security Act (Primary and/or Family Benefits); and/or
- any state compulsory/statutory benefit law.

## **DISABILITY INCOME INSURANCE: INCOME WHICH WILL REDUCE YOUR DISABILITY BENEFIT (continued)**

To apply for the Other Income benefits referenced above means to pursue such benefits with reasonable diligence until You receive the respective approval from the Social Security Administration and/or the appropriate state agency.

You must send Us Proof that You have applied for such benefits. If Your application for such benefits is approved, We will reduce Your Disability benefit by the amount actually paid to You from such source(s).

If You fail to:

- apply for any of the above referenced Other Income benefits; and
- pursue such benefits with reasonable diligence; and

if there is a reasonable means of estimating the amount of such benefits payable to You, We will reduce the amount of Your Disability benefit by the amount of such benefits We estimate that You, Your Spouse or child(ren) are eligible to receive because of Your Disability. We will start to do so with the first Disability benefit payment coincident with the date You were eligible to receive such benefits unless We have received:

- Proof that You have applied for and are pursuing such benefits with reasonable diligence;
- approval of Your claim for such benefits; or
- a notice of denial of such benefits.

When You do receive approval or notice of final denial of the above referenced Other Income benefits, You must notify Us immediately. We will adjust the amount of Your Disability benefit. You must promptly repay Us for any overpayment.

### **SINGLE SUM PAYMENT**

If You receive Other Income in the form of a single sum payment, You must, within 10 days after receipt of such payment, give Written Proof satisfactory to Us of:

- the amount of the single sum payment;
- the amount to be attributed to income replacement; and
- the time period for which the payment applies.

When We receive such Proof, We will adjust the amount of Your Disability benefit.

If We do not receive the Written Proof described above, and We know the amount of the single sum payment, We may reduce Your Disability benefit by an amount equal to such benefit until the single sum has been exhausted.

If We adjust the amount of Your Disability benefit due to a single sum payment, the amount of the adjustment will not result in a benefit amount less than the minimum amount, except in the case of an Overpayment.

If You receive Other Income in the form of a single sum payment and We do not receive the Written Proof described above within 10 days after You receive the single sum payment, We will adjust the amount of Your Disability Benefit by the amount of such payment.

**DISABILITY INCOME INSURANCE: INCOME WHICH WILL NOT REDUCE YOUR  
DISABILITY BENEFIT**

We will not reduce Your Disability benefit to less than the Minimum Benefit shown in the SCHEDULE OF BENEFITS or by any Other Income that is not shown in Income Which Will Reduce Your Disability Benefit.

## **DISABILITY INCOME INSURANCE: DATE BENEFIT PAYMENTS END**

Your Disability benefit payments will end on the earliest of:

- the end of the Maximum Benefit Period;
- the date benefits end as specified in the section entitled LIMITED DISABILITY BENEFITS;
- the date You are no longer Disabled;
- the date You die except for benefits paid under sections entitled ADDITIONAL LONG TERM BENEFIT: SINGLE SUM PAYMENT IN THE EVENT OF YOUR DEATH and ADDITIONAL LONG TERM BENEFIT: BENEFIT(S) IN THE EVENT OF YOUR TERMINAL ILLNESS;
- the date You fail to have a medical exam requested by Us as described in the Physical Exams subsection of the GENERAL PROVISIONS section;
- the date You fail to provide required Proof of continuing Disability.

While You are Disabled, the benefits described in this certificate will not be affected if:

- Your insurance ends; or
- the Group Policy is amended to change the plan of benefits for Your class.

## **DISABILITY INCOME INSURANCE**

### **ADDITIONAL LONG TERM BENEFIT: SINGLE SUM PAYMENT IN THE EVENT OF YOUR DEATH**

If You die while You are Disabled and You were entitled to receive Monthly Benefits under this certificate, Proof of Your death must be sent to Us. When We receive such Proof, We will pay the benefit described in this section.

#### **BENEFIT AMOUNT**

The benefit will be equal to 6 times the lesser of:

- the Monthly Benefit You receive for the calendar month immediately preceding Your death;
- in the event that You did not receive a Monthly Benefit for the calendar month immediately preceding Your death, the benefit will be calculated using the Monthly Benefit for the last calendar month for which You received a Monthly Benefit;
- the Monthly Benefit You receive for the calendar month immediately preceding Your Terminal Illness if Your Monthly Benefit amount was increased due to Your Terminal Illness; or
- the Monthly Benefit You were entitled to receive for the month You die, if You die during the first month that Disability benefits are payable.

We will reduce the benefit amount by any overpayment We are entitled to recover.

#### **BENEFIT PAYMENT**

Benefit payments will be made as described in the GENERAL PROVISIONS subsection entitled Disability Income Benefit Payments: Who We Will Pay.

This benefit will not be paid if You elect to receive a single sum payment under the Single Sum Payment in the Event of Your Terminal Illness subsection of the section entitled ADDITIONAL LONG TERM DISABILITY BENEFIT: BENEFIT(S) IN THE EVENT OF YOUR TERMINAL ILLNESS.

## **DISABILITY INCOME INSURANCE**

### **ADDITIONAL LONG TERM BENEFIT: BENEFIT(S) IN THE EVENT OF YOUR TERMINAL ILLNESS**

If You become Terminally Ill while You are Disabled and You are entitled to receive Monthly Benefits under this certificate, You or Your legal representative must send Proof of Your Terminal Illness to Us. When We receive such Proof, We will pay the benefit(s) described in this section.

**Terminally Ill or Terminal Illness** means for purposes of this and the section(s) entitled: **ADDITIONAL LONG TERM BENEFIT: SINGLE SUM PAYMENT IN THE EVENT OF YOUR DEATH** that due to injury or Sickness You are expected to die within 12 months.

#### **Proof of Your Terminal Illness**

You or Your legal representative must send Us a signed Physician's certification that You are Terminally Ill. We may also request an exam by a Physician of Our choice, at Our expense.

### **INCREASE IN YOUR MONTHLY BENEFIT**

We will increase Your Monthly Benefit amount beginning with the next payment due following receipt of Proof of Your Terminal Illness.

#### **BENEFIT AMOUNT**

We will increase Your Monthly Benefit percentage on any future payments made during Your lifetime, to 80% of the first \$1,875 of Your Predisability Earnings for Class 1 and 80% of the first \$20,000 of Your Predisability earnings for Class 2, for a maximum period of 12 consecutive monthly payments. In the event You remain Terminally Ill at the end of this period, and You remain Disabled, Your benefit under this subsection will cease, and Your Monthly Benefit will be paid in accordance with the **DISABILITY INCOME INSURANCE: LONG TERM BENEFITS** subsection.

The increased Monthly Benefit amount payable for Your Terminal Illness is subject to the subsection **OTHER BENEFIT SOURCES WHICH WILL REDUCE YOUR DISABILITY BENEFIT**. We will also reduce the benefit by any overpayment We are entitled to recover.

### **SINGLE SUM PAYMENT IN THE EVENT OF YOUR TERMINAL ILLNESS**

You may elect to receive the additional benefit described in this subsection. This benefit will be paid in a single sum. We will pay such benefit in addition to any other benefits We pay under this certificate.

#### **BENEFIT AMOUNT**

The additional benefit will be equal to 6 times the Monthly Benefit You receive for the calendar month immediately preceding the month You are diagnosed as Terminally Ill.

We will reduce the benefit amount by any overpayment We are entitled to recover.

If You elect to receive the additional benefit described here, no benefit will be paid under the **ADDITIONAL LONG TERM BENEFIT: SINGLE SUM PAYMENT IN THE EVENT OF YOUR DEATH** section.

## **DISABILITY INCOME INSURANCE: PRE-EXISTING CONDITIONS**

### **For Class 1:**

#### **Pre-existing Condition means You:**

- received medical treatment, care, or services for a diagnosed condition; or
- took prescribed medication for a diagnosed condition;

in the 12 months immediately prior to the effective date of coverage under this certificate; and the Disability caused or substantially contributed to by the condition begins in the first 12 consecutive months after the effective date of coverage under this certificate.

You are not covered for a Disability caused or substantially contributed to by a Pre-existing Condition or medical or surgical treatment of a Pre-existing Condition.

### **For Class 2:**

#### **Pre-existing Condition means You:**

- received medical treatment, care, or services for a diagnosed condition; or
- took prescribed medication for a diagnosed condition;

in the 3 months immediately prior to the effective date of coverage under this certificate; and the Disability caused or substantially contributed to by the condition begins in the first 12 consecutive months after the effective date of coverage under this certificate.

You are not covered for a Disability caused or substantially contributed to by a Pre-existing Condition or medical or surgical treatment of a Pre-existing Condition.

## **DISABILITY INCOME INSURANCE: LIMITED DISABILITY BENEFITS**

**For Disabilities Due to Alcohol, Drug or Substance Abuse or Addiction, Mental or Nervous Disorders or Diseases, Neuromuscular, Musculoskeletal or Soft Tissue Disorder, and Chronic Fatigue Syndrome**

If You are Disabled due to:

- alcohol;
- drug or substance addiction;
- Mental or Nervous Disorders or Diseases;
- Neuromuscular, musculoskeletal or soft tissue disorder including, but not limited to, any disease or disorder of the spine or extremities and their surrounding soft tissue; including sprains and strains of joints and adjacent muscles, unless the Disability has objective evidence of:
  - Seropositive Arthritis;
  - Spinal Tumors, malignancy, or Vascular Malformations;
  - Radiculopathies;
  - Myelopathies;
  - Traumatic Spinal Cord Necrosis; or
  - Myopathies; or
- Chronic fatigue syndrome and related conditions.

We will limit Your Disability benefits to a per occurrence maximum for any and all of the above equal to the lesser of:

- 24 months; or
- the Maximum Benefit Period.

If Your Disability is due to alcohol, drug or substance addiction, We require You to participate in an alcohol, drug or substance addiction recovery program recommended by a Physician. We will end Disability benefit payments at the earliest of the period described above or the date You cease, refuse to participate, or complete such recovery program.

If You are confined in a Hospital or Mental Health Facility at the end of the period shown above for which benefits are to be paid, We will continue Your Monthly Benefits until the end of Your Hospital or Mental Health Facility confinement.

We will determine if a Disability is the result of a Mental or Nervous Disorder or Disease.

This limitation will not apply to a Disability resulting from:

- schizophrenia;
- dementia; or
- organic brain disease;

For purposes of this provision, Mental Health Facility means a facility licensed in the jurisdiction in which it is located to provide care and treatment for a Mental or Nervous Disorder or Disease. Such facility must provide care on a 24 hour a day basis under the supervision of a staff of Physicians, and must provide a broad range of nursing care on a 24 hour a day basis by or under the direction of a registered professional nurse.

**Mental or Nervous Disorder or Disease** means a medical condition which meets the diagnostic criteria set forth in the most recent edition of the Diagnostic And Statistical Manual Of Mental Disorders as of the date of Your Disability. A condition may be classified as a Mental or Nervous Disorder or Disease regardless of its cause.

**DISABILITY INCOME INSURANCE: LIMITED DISABILITY BENEFITS (continued)**

**Seropositive Arthritis** means an inflammatory disease of the joints supported by clinical findings of arthritis plus positive serological tests for connective tissue disease.

**Spinal** means components of the bony spine or spinal cord.

**Tumor(s)** means abnormal growths which may be malignant or benign.

**Vascular Malformations** means abnormal development of blood vessels.

**Radiculopathies** means disease of the peripheral nerve roots supported by objective clinical findings of nerve pathology.

**Myelopathies** means disease of the spinal cord supported by objective clinical findings of spinal cord pathology.

**Traumatic Spinal Cord Necrosis** means injury or disease of the spinal cord resulting from traumatic injury with resultant paralysis.

**Myopathies** means disease of skeletal muscle supported by clinical, histological, biochemical and/or electrodiagnostic findings.

## **DISABILITY INCOME INSURANCE: EXCLUSIONS**

We will not pay for any Disability caused or contributed to by:

1. war, whether declared or undeclared, or act of war, insurrection, rebellion or terrorist act;
2. Your active participation in a riot;
3. intentionally self-inflicted injury;
4. attempted suicide; or
5. commission of or attempt to commit a felony.

## **FILING A CLAIM**

The Plan Sponsor should have a supply of claim forms. Obtain a claim form from the Plan Sponsor and fill it out carefully. Return the completed claim form with the required Proof to the Plan Sponsor. The Plan Sponsor will certify Your insurance under the Group Policy and send the certified claim form and Proof to Us.

When We receive the claim form and Proof, We will review the claim and, if We approve it, We will pay benefits subject to the terms and provisions of this certificate and the Group Policy.

## **CLAIMS FOR DISABILITY INSURANCE BENEFITS**

**When a claimant files an initial claim for Disability Income Insurance benefits described in this certificate, both the notice of claim and the required Proof should be sent to Us within 90 days after the end of the Elimination Period.**

Notice of claim and Proof may also be given to Us by following the steps set forth below:

### **Step 1**

A claimant may give Us notice by calling Us at the toll free number shown in the Certificate Face Page within 20 days of the date of a loss.

### **Step 2**

We will send a claim form to the claimant and explain how to complete it. The claimant should receive the claim form within 15 days of giving Us notice of claim.

### **Step 3**

When the claimant receives the claim form, the claimant should fill it out as instructed and return it with the required Proof described in the claim form.

If the claimant does not receive a claim form within 15 days after giving Us notice of claim, Proof may be sent using any form sufficient to provide Us with the required Proof.

### **Step 4**

The claimant must give Us Proof not later than 90 days after the end of the Elimination Period.

If notice of claim or Proof is not given within the time limits described in this section, the delay will not cause a claim to be denied or reduced if such notice and Proof are given as soon as is reasonably possible but, in no event, other than for lack of legal capacity, may Proof be given later than one year after the date it is otherwise required.

## **Items to be Submitted for a Disability Income Insurance Claim**

When submitting Proof on an initial or continuing claim for Disability Income insurance, the following items may be required:

- documentation which must include, but is not limited to, the following information:
  - the date Your Disability started;
  - the cause of Your Disability;
  - the prognosis of Your Disability;
  - the continuity of Your Disability; and
  - Your application for:
    - Other Income;
    - Social Security disability benefits; and
    - Workers compensation benefits or benefits under a similar law.
- Written authorization for Us to obtain and release medical, appointment and financial information and any other items We may reasonably require to document Your Disability or to determine Your receipt of or eligibility for Other Income;

## **FILING A CLAIM (continued)**

- any and all medical information, including but not limited to:
  - x-ray films; and
  - photocopies of medical records, including:
    - histories,
    - physical, mental or diagnostic examinations; and
    - treatment notes; and
- the names and addresses of all:
  - physicians and medical practitioners who have provided You with diagnosis, treatment or consultation;
  - hospitals or other medical facilities which have provided You with diagnosis, treatment or consultation; and
  - pharmacies which have filled Your prescriptions within the past three years.

### **Regular Care of a Physician Requirement**

In addition, You must be under the Regular Care of a Physician unless Regular Care:

1. will not improve the condition(s) causing Your Disability; or
2. will not prevent a worsening of the condition(s) causing Your Disability.

**Regular care means:**

1. You personally visit a Physician(s) as frequently as is medically required to effectively manage and treat the condition(s) causing Your Disability; and
2. You are receiving appropriate treatment and care which conforms with generally accepted medical standards for the condition(s) causing Your Disability.

Prior to the initial payment of benefits, provided You are receiving appropriate treatment and care which conforms with generally accepted medical standards for the condition(s) causing Your Disability, if the time period between Your visits to a Physician(s) is reasonable, You will be deemed to have satisfied the Regular Care of a Physician requirement, even if this results in a visit to a Physician(s) occurring after the end of the Elimination Period.

**Time Limit on Legal Actions.** A legal action on a claim may only be brought against Us during a certain period. This period begins 60 days after the date Proof is filed and ends 3 years after the date such Proof is required.

## **GENERAL PROVISIONS**

### **Assignment**

The rights and benefits under the Group Policy are not assignable prior to a claim for benefits, except as required by law. We are not responsible for the validity of an assignment.

### **Disability Income Benefit Payments: Who We Will Pay**

We will make any benefit payments during Your lifetime to You or Your legal representative. Any payment made in good faith will discharge Us from liability to the extent of such payment.

Upon Your death, We will pay any amount that is or becomes due to Your designated Beneficiary. If there is no Beneficiary designated or no surviving Beneficiary at Your death, We will pay any benefit that is or becomes due, according to the following order:

1. Your Spouse or Domestic Partner, if alive;
2. Your unmarried child(ren) under age 25; if there is no surviving Spouse or Domestic Partner; or
3. Your estate, if there is no such surviving child.

If more than one person is eligible to receive payment, We will divide the benefit amount in equal shares.

Payment to a minor or incompetent will be made to such person's guardian. The term "children" or "child" includes natural and adopted children.

Any periodic payments owed to Your estate may be paid in a single sum. Any payment made in good faith will discharge Us from liability to the extent of such payment.

### **Entire Contract**

Your insurance is provided under a contract of group insurance with the Plan Sponsor. The entire contract with the Plan Sponsor is made up of the following:

1. the Group Policy and its Exhibits, which include the certificate(s);
2. the Plan Sponsor's application; and
3. any amendments and/or endorsements to the Group Policy.

### **Incontestability: Statements Made by You**

Any statement made by You will be considered a representation and not a warranty. We will not use such statement to avoid Insurance, reduce benefits or defend a claim unless the following requirements are met:

1. the statement is in a Written application or enrollment form;
2. You have Signed the application or enrollment form; and
3. a copy of the application or enrollment form has been given to You or Your Beneficiary.

We will not use Your statements which relate to insurability to contest Disability Insurance after it has been in force for 2 years during Your life, unless the statement is fraudulent. In addition, We will not use such statements to contest an increase or benefit addition to such insurance after the increase or benefit has been in force for 2 years during Your life, unless the statement is fraudulent.

### **Misstatement of Age**

If Your age is misstated, the correct age will be used to determine if insurance is in effect and, as appropriate, We will adjust the benefits and/or premiums.

## **GENERAL PROVISIONS (continued)**

### **Conformity with Law**

If the terms and provisions of this certificate do not conform to any applicable law, this certificate shall be interpreted to so conform.

### **Physical Exams**

If a claim is submitted for insurance benefits, We have the right to ask the insured to be examined by a Physician(s) of Our choice as often as is reasonably necessary to process the claim. We will pay the cost of such exam.

### **Autopsy**

We have the right to make a reasonable request for an autopsy where permitted by law. Any such request will set forth the reasons We are requesting the autopsy.

### **Overpayments for Disability Income Insurance**

#### **Recovery of Overpayments**

We have the right to recover any amount that We determine to be an overpayment.

An overpayment occurs if We determine that:

- the total amount paid by Us on Your claim is more than the total of the benefits due to You under this certificate; or
- payment We made should have been made by another group plan.

If such overpayment occurs, You have an obligation to reimburse Us. Our rights and Your obligations in this regard are described in the reimbursement agreement that You are required to sign when You submit a claim for benefits under this certificate. This agreement:

- confirms that You will reimburse Us for all overpayments; and
- authorizes Us to obtain any information relating to sources of Other Income.

#### **How We Recover Overpayments**

We may recover the overpayment from You by:

- stopping or reducing any future Disability benefits, including the Minimum Benefit, payable to You or any other payee under the Disability sections of this certificate;
- demanding an immediate refund of the overpayment from You; and
- taking legal action.

If the overpayment results from Our having made a payment to You that should have been made under another group plan, We may recover such overpayment from one or more of the following:

- any other insurance company;
- any other organization; or
- any person to or for whom payment was made.

**THIS IS THE END OF THE CERTIFICATE.  
THE FOLLOWING IS ADDITIONAL INFORMATION.**

EXHIBIT 1 - 51